This form may be completed online, printed and mailed to the address listed below.

Department of Health & Human Services Regulation and Licensure
Credentialing Division, PO Box 94986
Lincoln NE 68509-4986
(402)471-4364 or fax (402)471-1066

APPLICATION FOR TESTING REGISTRATION: MEDICATION AIDE

Personal Information:

Name:_____
(Last) (First) (Middle)

_____
(Maiden) (Previously used names)

Address: _____
(Street) (City) (State) (Zip)

Telephone (optional): (H)_____ (W)_____

Date of Birth _____ Place of Birth _____ Social Security # _____

Examination Eligibility:

Person/Entity providing the course _____

Length of course ☐ 40 hr ☐ addt'l 20 hr Date of course completion _____

State Examination Location:

Examination Site _____ Date _____

Confirmation of registration for medication aide exam and time of exam will be mailed to you at the address provided above.

OFFICE USE ONLY

Examination Time: _____

Examination Score: _____

Applicant Signature_____

Date _____

A complete application includes:

1. **Testing application containing the required information.**
2. **Fee of $10.00 – non-refundable.**
3. **Testing application and fee should be mailed to:**

Department of Health and Human Services Regulation and Licensure
Credentialing Division
PO Box 94986
Lincoln, NE 68509-4986

07/04